Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: JAMES D WEISS, MD 3100 TIMMONS LANE #250 HOUSTON, TX 77027	MFDR Tracking #: M4-10-4100-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: INDEMNITY INSURANCE CO OF NORTH Box #: 15	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a position summary in accordance with rule §133.307.

Amount in Dispute: $638.06*

PART III: RESPONDENT'S POSITION SUMMARY

The Respondent did not respond.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
11/6/09	99243	53.68 ÷ 36.0666 x $126.76 = $188.66	$0.21	$0.00
11/6/09	95861	53.68 ÷ 36.0666 x $118.57 = $176.47	$0.19	$0.00
11/6/09	95900-59	53.68 ÷ 36.0666 x $52.54 = $78.20 x 3 = $234.60	$469.68	$234.60
11/6/09	95903	53.68 ÷ 36.0666 x $61.75 = $91.91 x 6 = $551.46	$0.42	$0.0
11/6/09	95904	53.68 ÷ 36.0666 x $46.40 = $69.06 x 6 = $414.36	$0.42	$0.00
11/6/09	99070	N/A	$25.00	$0.00
			Total Due:	$234.60

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

* The requestor listed the total amount of disputed services on the DWC-60 table as $638.06. The actual amount is $495.92.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 4/2/2010

   - 861 – (871-002) Services are not payable as documentation does not support the services rendered.

Issues

1. Does the submitted documentation support the services billed under CPT code 95900-59?
2. Did the carrier reimburse the requestor the MAR amount for CPT codes 99243, 95861, 95903 and 95904?
3. Is CPT code 99070 a bundled code?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT code 95900-59. The carrier denied this service with reason code 861 – (871-002) Services are not payable as documentation does not support the services rendered. The description of CPT code 95900-59 is as follows: nerve conduction study, amplitude and latency/velocity study, each nerve; motor, without F-wave study. The 59 modifier describes "separate procedure". The requestor's documentation submitted to support the services is reviewed. It supports results of a nerve conduction study performed on the median, ulnar and radial motor nerves without F-wave **bilaterally.** The requestor billed CPT code 95900-59 x 6 units. The Medicare guidelines support that CPT code 95900 has a bilateral surgery indicator status of "0" which means that payment for bilateral procedures does not apply. Therefore reimbursement for CPT code 95900-59 x 3 units is recommended.
2. Pursuant to rule §134.203(c)(1)(2), To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor is to be applied. The conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. Commissioner's Bulletin #B-0075-08 states for services provided in calendar year 2009, the Medical Fee Guideline conversion factors in rule §134.203(c) are $53.68 and $67.38. The conversion factor of $53.68 applies to service categories of Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting. The requestor billed the following CPT codes: 99243, 95861, 95903 and 95904. The following is the MAR amount for each of these codes and the reimbursement by the Respondent:

   99243 – MAR amount = $188.66. Requestor billed $188.87. Respondent paid $188.66. No additional due.

   95861 – MAR amount = $176.47. Requestor billed $176.66. Respondent paid $176.47. No additional due.

   95903 – MAR amount = $91.91 x 4 units = $551.46. Requestor billed $552.00. Respondent paid $551.46. No additional due.

   95904 – MAR amount = $69.06 x 4 units = $414.36. Requestor billed $414.78. Respondent paid $414.36. No additional due.
3. The requestor also billed CPT code 99070. The description of CPT code 99070 is as follows: Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered. (list drugs, trays, supplies, or materials provided). The Requestor's documentation does not document any supplies and materials. Per NCCI edits, CPT code 99070 is always bundled into payment of other services. Therefore, reimbursement for CPT code 99070 is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $234.60.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $234.60 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

		11/9/10
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.